

COVID-19 Dental Treatment Consent Form

I, _____, knowingly and willingly consent to having dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19.

Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can transmit the COVID-19 virus. Therefore, with the use of ultrasonic cleaning, we use an extra-oral high volume suction that greatly diminishes the exposure to the aerosols created.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 for the past 2 weeks listed below (circle all that pertain):

- Fever
- Chills
- Altered taste or smell
- Body aches/muscle soreness
- Chest pain
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat
- Any other altered normal health condition
_____ (Initial)

Have you been in contact with anyone who was sick? Y N

Have you attended large group functions/meetings/gatherings? Y N

Have you been tested for Covid 19? Y N If so, Positive or Negative? P N

Are you over 65 and/or have pre-existing health condition related to the following (circle all that pertain):

- Diabetes
- Chronic lung disease or asthma
- Serious heart condition
- Immune-compromised
- Chronic kidney or liver disease

_____ (Initial)

I understand that mass transit travel (bus, train, plane, ferry) significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has used mass transit, and this distance is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled within the United States by commercial airline, bus, ferry, or train within the past 14 days. _____ (Initial)

If you are unable to print this form and email it, please copy and paste the questionnaire into a composed email and send it to the office email (info@bellportvillagedentist.com) .

By typing your name in the space provided and return by e-mail indicates your understanding of an informed consent of these terms.

Name _____ Date _____